CHECK ONE: ☐ DENTIST'S PRE TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

ORGANIZATION

## LOCAL 3 EMPLOYEE SECURITY FUND

1. PATIENT NAME:

2. RELATIONSHIP TO EMPLOYEE SELF | SPOUSE | CHILD | OTHER

3. SEX M | F

4. PATIENT BIRTHDATE MO. | DAY | YEAR

5. IF FULL TIME STUDENT SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME First Middle Last

7. EMPLOYEE SOC. SEC. NO.

8. EMPLOYER (COMPANY) NAME AND ADDRESS

9. EMPLOYEE/SUBSCRIBER MAILING ADDRESS

CITY, STATE, ZIP

ELIGIBILITY DATE

CARD NUMBER APPROVAL DATE

10. GROUP NO. 11. IS SPOUSE EMPLOYED? ☐ YES ☐ NO Employee Name Soc. Soc. No. Date of Birth 12. NAME AND ADDRESS OF EMPLOYER IN ITEM 11

13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? DENTAL PLAN NAME UNION LOCAL GROUP NO. NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE SIGNED (INSURED PERSON) DATE

14. DENTIST NAME DR. CODE.

15. MAILING ADDRESS

CITY, STATE, ZIP

16. DENTIST (Soc. Sec. or TIN) 17. DENTIST LIC NO. 18. DENTIST PHONE NO.

19. Is Treatment Result of Occupational Illness or Injury? NO YES IF YES, ENTER BRIEF DESCRIPTION & DATES

20. Is Treatment Result of Auto Accident?

21. Other Accident?

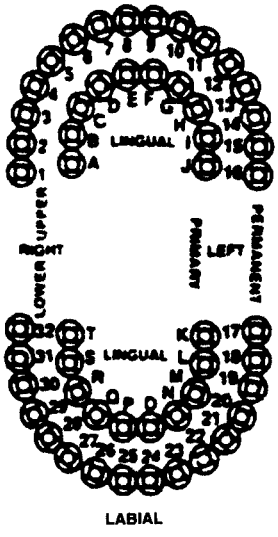
22. Are Any Services Covered by Another Plan

23. If Prosthetics, is this initial Placement? (If NO, reason for replacement) 25. Date of Prior Placement

REMARKS FOR UNUSUAL SERVICES

D.D.S. INFO

INDICATE MISSING TEETH WITH AN "X"




EXAMINATION AND TREATMENT RECORD-LIST IN ORDER FROM TOOTH NO.1 THROUGH TOOTH NO.32

| TOOTH NO. LETTER/ QUAD | SUR-FACES | (INCLUDING X-RAYS, PROPHLAXIS MATERIAL USED, ETC.) | DATE SERVICE PERFORMED MO. | DAY | YR. | ADA PROCEDURE NUMBER | FEE | FOR ADMINIS-TRATIVE USE ONLY | CO-PAY |
|---|---|---|---|---|---|---|---|---|---|
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If the treatment exceeds $300.00 then this form and the patient's x-rays must be sent to the address below for pre-authorization. Pre and post op x-rays required on all unauthorized root canals

TOTAL

Date _____

Previous Utilization _____

Total Fees Covered _____

Patient Pays _____

Approved _____

Approved With Limitation _____

Disapproved _____

Approved By _____

| | |
|---|---|
| PREVIOUS UTILIZATION TO DATE | |
| AMOUNT BILLED YEAR | |
| DEDUCTIBLE | |
| PATIENT PAYS | |

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE OF SERVICES, HAVE BEEN PERFORMED

SIGNED (Dentist)

DATE

Benefits will be paid, provided that members insurance is in force at the time services are rendered, and subject to coordination of benefits, limitations and exclusions and remaining maximum at the time of submission for payments,.

® GCU 247-C

**REMOVE ALL X-RAYS WHEN SUBMITTING FOR PAYMENT ON AUTHORIZED WORK.**
**MAIL CLAIM FORMS TO: DDS., INC. 1640 HEMPSTEAD TURNPIKE, EAST MEADOW, NY 11554-1040 (516) 794-7700**